



File No:

313

Name: <u>TAWAAN DUTT</u>			
Mobile no.: <u>056 137444</u>	Email: <u>PAVANI.SAUVANA@gmail.com</u>		
Date of Birth: <u>28-08-2017</u>	Sex: <input checked="" type="radio"/> M <input type="radio"/> F	Nationality: <u>Indian</u>	
How do you know about us? <input checked="" type="radio"/> Family or Friends <input type="radio"/> Internet <input type="radio"/> Newspapers <input type="radio"/> Others			

## MEDICAL HISTORY

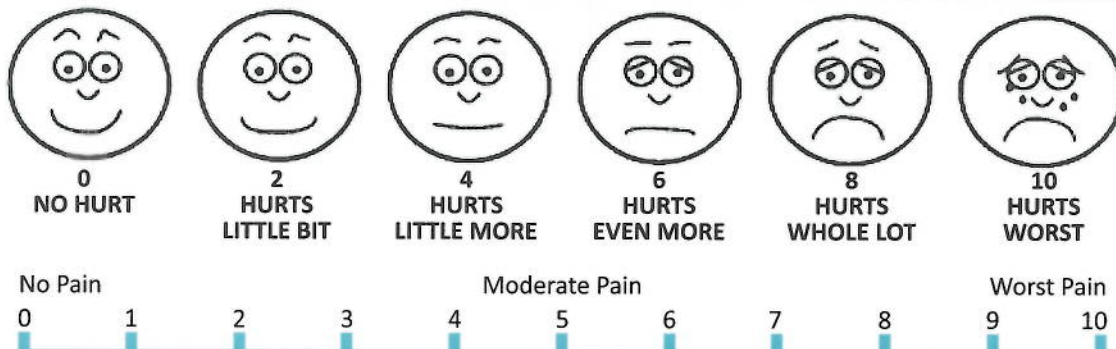
Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by answering the questions.

Chief Complaint: \_\_\_\_\_

All details will be strictly confidential.	Yes	No	Others, Please Specify
Are you under a physician's care now?		<input checked="" type="checkbox"/>	
Are you taking any medications, pills, or drugs?	<input checked="" type="checkbox"/>		
Have you ever been hospitalized or had a major operation?		<input checked="" type="checkbox"/>	
Have you ever had any complications following dental treatment?			
Are you a smoker?		<input checked="" type="checkbox"/>	
<b>Do you have, or have you had any of the following</b>			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Fainting / Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> AIDS/HIV Infection
<input type="checkbox"/> Creutzfeldt-Jakob disease (CJD)	<input type="checkbox"/> Others, Please Specify <u>N/A</u>		
<b>Are you allergic, or have you reacted adversely to any of the following:</b>			
Local anesthetics (Novocaine)	Yes	No	Others, Please Specify
Penicillin or other antibiotics			
Asperin or Ibuprofen			
Reactions to metals			
Latex or rubber dam			
Foods			
<b>Additional questions for women.</b>			
Are you pregnant or trying to get pregnant?	Yes	No	Others, Please Specify
if yes, expected delivery date: _____			
Are you taking oral contraceptives?			

PLEASE SELECT THE NUMBER THAT BEST REPRESENTS YOUR CURRENT PAIN INTENSITY



To the best of my knowledge, all of the preceding answer and information provided are true and correct.  
If I ever have any change in my health, I will inform the doctor at the next appointment without fail.